Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
ARCH INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-03-2876-02

MFDR Date Received
February 11, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the patient was admitted for five days for medical inpatient services. Therefore, in accordance with the formula, the WCRA is 5 X $87.00 = $4,350.00. The prior amounts piad by the carrier were $0. Therefore, the Carrier is required to reimburse the remainder of the Worker's Compensation Reimbursement amount of $4,350.00, plus interest."

Amount in Dispute: $5,590.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position statement for consideration in this review.

Response Submitted by: First American Insurance, PO BOX 819045, Dallas, Texas 75381

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2002 to February 27, 2002	Inpatient Hospital Services	$5,590.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305 set forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. Former 28 Texas Administrative Code §133.206 established a spinal surgery second opinion process.
5. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization of health care.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - M – REDUCED TO FAIR AND REASONABLE
   - V – UNNECESSARY TREATMENT WITH PEER REVIEW
   - O – DENIAL AFTER RECONSIDERATION

Issues

1. Are there unresolved issues of medical necessity pertaining to the services in dispute?
2. Is the second opinion spinal surgery process described in former 28 Texas Administrative Code §133.206 applicable to the services in dispute?
3. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The provider denied disputed services with payment exception code V – "UNNECESSARY TREATMENT WITH PEER REVIEW." Former 28 Texas Administrative Code §133.305(a)(2), effective January 1, 2003, 27 *Texas Register* 12282, defines a medical fee dispute as "a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care." 28 Texas Administrative Code §133.305(b) requires that "The medical necessity dispute will be resolved pursuant to §133.308 of this title prior to deciding the medical fee dispute pursuant to §133.307 of this title." The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved.
2. Documentation was presented to support that the provider sought and received preauthorization for the disputed services through the Spinal Surgery Second Opinion Process provided by Division rule in former 28 Texas Administrative Code §133.206. Per 28 Texas Administrative Code §134.600(n), effective January 1, 2002, 26 *Texas Register* 9874, "Section 133.206 of this title (relating to Spinal surgery Second Opinion Process) will remain in effect only for recommendations or resubmissions of recommendations for spinal surgery submitted prior to the effective date of this section." The Result of Spinal Surgery Second Opinion Process notification is dated January 23, 2002. This date is after the effective date of applicable §133.600(n). No documentation was found to support a recommendation or resubmission of recommendation for spinal surgery prior to January 1, 2002. Therefore, the Division concludes that §133.206 is not applicable to the services in dispute.
3. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the disputed issues regarding medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413. Therefore, Medical Fee Dispute Resolution staff have no authority to consider the medical fee issues or order any payment in this dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	December 11, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.